Wisconsin Department of Safety and Professional Services

Mail To: **P.O. Box 8935**
Madison, WI 53708-8935
1400 E. Washington Avenue
Madison, WI 53703
FAX #: (608) 261-7083
Phone #: **(608) 266-2112**
E-Mail: web@dsps.wi.gov
Website: http://dsps.wi.gov

$10.00 Temporary Permit Fee

CHIROPRACTIC EXAMINING BOARD

APPLICATION FOR TEMPORARY CHIROPRACTIC LICENSE

Under Wisconsin law, the Department must deny your application if you are liable for delinquent state taxes or child support (sec. 440.12, Stats.).

PLEASE TYPE OR PRINT IN INK ☐ Your name and address are available to the public.
Check box to withhold street address/PO Box number from lists of 10 or more credential holders (Wis. Stat. § 440.14)

Last Name	First Name	MI	Former / Maiden Name(s)

Your Street Address (number, street, city, state, zip)

Mail To Address (if different)

Date of Birth
_____ _____ _____
month day year

Daytime Telephone Number
( ) _____ - _____

Ethnic/gender status information is optional.

Sex: ☐ M ☐ F

Ethnic: ☐ White, not of Hispanic origin ☐ Black, not of Hispanic origin ☐ Hispanic ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Other

Have you ever held a license/credential in the state of Wisconsin? _____Yes _____No (please indicate)
If yes, provide your Wisconsin license/credential number. _____

1. COLLEGE OF CHIROPRACTIC _____ SCHOOL CODE _____ GRADUATION DATE _____

2. LIST STATE(S) IN WHICH YOU ARE LICENSED AS A CHIROPRACTOR.

State	License Number	Date Issued

3. HAVE YOU BEEN ENGAGED IN THE ACTIVE PRACTICE OF CHIROPRACTIC IN ONE OR MORE JURISDICTIONS IN WHICH YOU HAVE A CURRENT LICENSE?
☐ YES ☐ NO If yes, list:

City/State	Dates

4. IS YOUR CHIROPRACTIC LICENSE NOW SUBJECT TO DISCIPLINARY PROCEEDINGS IN ANOTHER STATE?
☐ YES ☐ NO If yes, in which state?

5. HAS YOUR LICENSE(S) TO PRACTICE CHIROPRACTIC EVER BEEN DENIED, RESTRICTED, REVOKED, SUSPENDED, LIMITED, SURRENDERED OR CANCELLED, OR HAS ANY OTHER DISCIPLINARY ACTION BEEN TAKEN AGAINST YOUR LICENSE(S) IN ANY OTHER JURISDICTION?
☐ YES ☐ NO If yes, give details on an attached sheet.

For Receipting Use Only

6. HAVE YOU EVER BEEN CONVICTED OF ANY VIOLATION OF LAW GOVERNING THE PRACTICE OF CHIROPRACTIC?
   ☐ YES ☐ NO If yes, give details on an attached sheet.

7. HAVE YOU OR YOUR CLINIC EVER BEEN THE DEFENDANT IN A LAWSUIT ALLEGING ANY FORM OF MALPRACTICE OR INCOMPETENCE IN THE PRACTICE OF CHIRPRACTIC OR ANY OTHER PROFESSIONAL SERVICES?
   ☐ YES ☐ NO If yes, submit a copy of the suit or claim of the final settlement or disposition.

A "YES" ANSWER TO THE FOLLOWING QUESTION IS NOT AUTOMATIC DENIAL OF LICENSE. A FORM WILL BE SENT TO YOU REQUESTING SPECIFIC INFORMATION RELATIVE TO YOUR CONVICTION/ARREST RECORD.

8. HAVE YOU EVER BEEN CONVICTED OF A FELONY OR MISDEMEANOR?
   ☐ YES ☐ NO If yes, give details on an attached sheet.

9. STATE THE PURPOSE OF THE TEMPORARY LICENSE
   ☐ **ATHLETIC EVENT/** ☐ **ARTISTIC EVENT**

   IDENTIFY THE ORGANIZATION(S) YOU WILL BE ACCOMPANYING:

   _____
   _____
   _____

   LIST THE LOCATION(S) and DATE(S) OF THE EVENT(S):

   _____ _____
   _____ _____
   _____ _____
   (Locations) (Dates)

   ☐ **INSTRUCTOR FOR A SPECIFIC EDUCATION SEMINAR.** LIST THE EDUCATIONAL SEMINAR SPONSOR(S), NAME OF COURSES(S), AND DATE(S):

   _____ _____
   _____ _____
   _____ _____
   (Sponsors) (Courses)

   _____ _____
   _____ _____
   _____ _____
   (Locations) (Dates)

   (Use Additional Sheets If Necessary)

CERTIFICATION OF LEGAL STATUS.

I declare under penalty of law that I am (check one):

_____ a citizen or national of the United States, or

_____ a qualified alien or nonimmigrant lawfully present in the United States who is eligible to receive this professional license or credential as defined in the Personal Responsibility and Work Opportunities Reconciliation Act of 1996, as codified in 8 U.S.C. §1601 et. seq. (PRWORA). For questions concerning PRWORA status, please contact the U.S. Citizenship and Immigration Services in the Department of Homeland Security at 1-800-375-5283 or online at http://www.uscis.gov.

Wisconsin Department of Safety and Professional Services

ALL APPLICANTS MUST COMPLETE THIS SECTION

AFFIDAVIT OF APPLICANT

(Sign and date <u>in the presence of</u> a notary)

I declare that I am the person referred to on this application and that all answers set forth are each and all strictly true in every respect. I understand that failure to provide requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential or for renewal or reinstatement of a credential may result in credential application processing delays; denial, revocation, suspension or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. I further understand that if I am issued a credential, or renewal or reinstatement thereof, failure to comply with the statutes and/or administrative code provisions of the licensing authority will be cause for disciplinary action.

_____ _____

Signature of Applicant Date

State of _____ County of _____

Subscribed and sworn to before this _____ day of

_____, 20_____, by _____

(Applicant name)

_____

Signature of Notary Public

S E A L

_____

Date Commission Expires

Wisconsin Department of Safety and Professional Services

SOCIAL SECURITY NUMBER. Your social security number (or employer identification number if you are applying as a business entity) must be submitted with your application on this form. If you do not have a social security number you must submit a statement under oath or affirmation. If your social security number or a statement is not provided, your application will be denied.[1] A form for submitting a statement that you do not have a social security number is available from the department.

(Please Print)

_____

First Name **Middle Initial** **Last Name**

_____

Profession

Date of Birth _____ _____ _____

month day year

☐☐☐ - ☐☐ - ☐☐☐☐

Social Security Number or FEIN

The Department may not disclose the social security number collected above except to the Department of Children and Families for purposes of administering the child and spousal support program,[2] to the Department of Revenue for the purpose of determining whether you are liable for delinquent taxes,[3] and to the federal Healthcare Integrity and Protection Data Bank for the purpose of reporting adverse actions against health care practitioners.[4]

EMAIL ADDRESS:

Do you have an email address? ☐ **Yes** ☐ **No**

If yes, this field is required to receive your application status electronically. Your email address must be clearly legible with the correct case sensitive information.

EMAIL ADDRESS: Submit your email address in the spaces provided below or attach a printer copy.

If no, your checklist will be sent by first class mail.

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[1] Section 440.03 (11m), Wis. Stats.

[2] Sections 49.22, and 440.13, Wis. Stats.

[3] Section 440.12, Wis. Stats.

[4] Health Insurance Portability and Accountability Act (HIPAA) of 1996

This form is authorized by secs. 440.12 and 440.14, Wis. Stats. Making a false statement in connection with this application may result in revocation or denial.